Health Care Price Transparency Initiatives Are All the Rage

But Burgeoning Efforts Suffer from Myriad Shortcomings

Stephen Barlas

When a House–Senate conference committee passed the Department of Health and Human Services' (HHS) appropriations bill for fiscal 2019 in September, a Senate-passed amendment in the Senate version of the bill that required drug companies to disclose drug prices in their television (TV) ads was not included. It was dropped from the final bill because the House HHS appropriations bill did not include that measure. A "drug TV ad" bill was introduced in the House, co-sponsored by Representative Michael Burgess (R–TX), chairman of the House health subcommittee, and Representative Jan Schakowsky (D–IL), also a member of the subcommittee. But it never saw the light of day on that side of Capitol Hill. It never came up on its own and it was never offered as part of the House HHS bill, even though it had the support of President Donald Trump.

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Senator Bill Cassidy, MD, (R-LA), a Senate co-sponsor of the bill, said the HHS conference committee booted the Senate amendment from the final bill because "the DC swamp killed it." Cassidy did not identify which reptiles swimming in the lagoon swallowed the amendment, nor did his press secretary want to address the issue. Nor did Burgess' press secretary respond to a query about why the House version of the drug-price transparency bill was consigned to a legislative grave.

"In health care, too often transparency is compromised by smoke and mirrors meant to protect sensitive special interests," said Leah Binder, president and chief executive officer of The Leapfrog Group, at Senate hearings in September 2018. She was speaking in general terms.

Health care transparency is a big issue in Congress, in the Trump administration, and in many states with innovative bills cropping up from coast to coast. And rightly so. A 2018 Gallup poll found that a greater percentage of Americans (55%) stated that they worry "a great deal" more about the availability and affordability of health care than about 14 other major social issues such as crime, the economy, unemployment, terrorist attacks, and the availability of guns.

There is good cause, of course, for public concern about opaque health care prices. For instance, a 2014 study by the U.S. Government Accountability Office found that the estimated cost of maternity care at select, high-quality, acute-care hospitals in the Boston area ranged from $6,834 to $21,554, a difference of more than 200 percent. More recently, a 2018 study found that the median price of a magnetic resonance imaging (MRI) scan of the spine ranges from $500 to $1,670 in Massachusetts, which is also more than a 200-percent difference.

Mr. Barlas is a freelance writer in Washington, D.C., who covers issues inside the Beltway. Send ideas for topics and your comments to sbarlas@verizon.net.

Transparency is a bigger issue for some than for others. Medicare recipients with supplemental insurance don't need to price-shop. Neither do Medicaid recipients, for the most part. But the costs of drugs, tests, physician visits, and hospital visits, whether inpatient or outpatient, are critical for uninsured individuals and those with high-deductible policies from health insurance exchanges or an employer. In addition, all payers (as opposed to consumers) are concerned with costs, especially state Medicaid programs, federal Medicare, employers with self-insured plans, and probably, to a lesser extent, insurance companies.

Health insurers and some employers do make cost estimators available. However, their accuracy and usefulness are impaired because they are almost always based on average costs in an area, not on what specific charge a specific physician or hospital is likely to insist on. Moreover, these medical cost estimates rarely go as far as telling individuals what their out-of-pocket costs will be based on their insurance benefits, when they have benefits. So anyone using these cost estimators is well-advised to hold his or her breath when the actual bill comes in. A Bloomberg article entitled *Priced Out of Health Insurance, Americans Rig Their Own Safety Nets* told the story of an Aetna-insured couple with an individual policy who used the company's calculator to estimate the costs of their child's upcoming birth. According to the article: "A calculator on her Aetna health plan's website estimated the Bergevins would need to pay about $3,000 or $4,000 out-of-pocket for Sky's birth. When the total bill came, the sum for prenatal care, hospital costs, anesthesia, and other care was triple the estimate."[1]

T. J. Crawford, an Aetna spokesman, declined to comment on the story or on whether Aetna has attempted to check the accuracy of its cost calculator.

"Overall, the evidence, unfortunately, suggests that the impact of transparency has been minimal," states Michael Chernew, MD, a professor in the Department of Health Care Policy at Harvard Medical School.

In Congress: Many Hearings, Little Substantial Action

Given what has been a national uproar over health care prices, particularly drug costs, both Congress and the Trump administration have attempted to seize the upper political hand. Despite dropping the TV ad bill, Congress passed and President Trump signed two bills prohibiting pharmacy benefit managers (PBMs) from enforcing so-called "gag clauses" on pharmacies, where the PBM's contract with the pharmacy prohibits pharmacists from telling customers when paying for a drug outside of their health insurance plan would save money. However, the Pharmaceutical Care Management Association, which represents PBMs—allegedly the villains in the gag-clause story—supported the bill and argued that gag clauses

are infrequent. Therefore, this was an easy transparency vote for Congress reflected in the near-unanimous votes for the bill in both houses of Congress.

Other, potentially more significant measures—such as the "price disclosure in TV ads" bill—didn't fare so well. Schakowsky's Fair Accountability and Innovative Research Drug Pricing Act (H.R. 2439) did even worse. It has gone nowhere since it and a Senate version were introduced in May 2017. The act would require drug companies to report to HHS an increase of more than 10 percent in a year in the price of certain drugs, and submit transparency and justification reports before increasing the price of certain drugs by 10 percent. The Senate version (S. 1131) was introduced at the same time by Senator Tammy Baldwin (D-Wisc.), and co-sponsored by the now-deceased Senator John McCain (R-AZ). The Schakowsky bill has a couple of GOP co-sponsors, too, but both bills disappeared from view the moment they were introduced. Schakowsky, who made health care the top issue in her 2018 re-election campaign, did not reply to an e-mail asking why her bill never even received a hearing in the Senate despite the Health, Education, Labor and Pensions Committee holding multiple hearings on health care costs.

Ditto for Senator Ron Wyden's (D-OR) Creating Transparency to Have Drug Rebates Unlocked bill (S.637). That bill requires PBMs to publish on their websites: (1) the amount and type of rebates and discounts negotiated by the PBM and the extent to which these rebates and discounts are passed on to the plan sponsor, and (2) the difference between the amount paid by the plan sponsor to the PBM and the amount paid by the PBM to pharmacies.

Representative Frank Pallone (D-NJ), the top Democrat on the House Energy and Commerce Committee, who fashions himself as a consumer advocate on health issues, helps explain why Congress has not been more successful in passing health care transparency legislation. At a hearing in July 2018, he said, "However, we should be cautiously optimistic about greater transparency, as we have seen only modest results in actually bringing down costs. Some studies have found an increase in prices with more transparency, so we should be mindful of these results before considering any reforms."

At the Federal Agencies

The White House has occasionally stepped in where Congress has feared to tread. The failure to include the "drug price in TV ads" bill in the HHS appropriations bill led to HHS Secretary Alex Azur announcing on October 15, 2018, that the Trump administration would pursue a regulation forcing pharmaceutical manufacturers to disclose in TV ads the list price of a 30-day supply of any drug that is covered through Medicare and Medicaid and costs more than $35 a month. The final shape of that rule won't be determined for months. Azur's announcement came on the same day the Pharmaceutical Research and Manufacturers of America (PhRMA) announced that by next April, drug manufacturers would voluntarily direct consumers viewing TV ads to the pharmaceutical company's website. There consumers would find information about medicine costs, including the list price of the medicine, out-of-pocket costs, or other context about the medicine's potential cost and available financial assistance.

Azur called PhRMA's announcement "a small step in the right direction" but criticized the industry for remaining "resistant to providing real transparency around their prices, including the sky-high list prices that many patients pay."

However, neither PhRMA's nor the administration's initiative will give consumers the depth of knowledge they need to assess the impact of a drug's list price on their pocketbooks. That would require receiving, at the same time, information on how the list price factors into their co-pay and deductible, or, when someone is uninsured, what discounts might be available and from whom, whether rebates are available at the pharmacy counter, and much more information. What would be more helpful would be a requirement that someone somewhere publish an easy-to-use website listing FDA-approved drugs, category by category, and their list prices, so consumers could compare list prices of brand-name drugs and generics for the same illness. That would still leave questions unanswered, but it would be a more muscular approach to drug-price transparency than what either PhRMA or the Trump administration are proposing.

The Trump administration is taking other, incremental steps on price transparency. Effective January 1, 2019, the Centers for Medicare and Medicaid Services (CMS) is requiring hospitals to make available online a list of their current standard charges in a machine-readable format and to update this information at least annually, or more often as appropriate. Since 2015, hospitals have been required to post "chargemaster data" for diagnosis-related groups (DRGs), but those data are essentially useless as guidance on what a hospital will charge, since various data lines have to be added up to come up with a price for any particular service. In a letter to the CMS, Reverend Dennis H. Holtschneider, the executive vice president and chief operations officer at Ascension Health, wrote: "We agree with CMS that chargemaster data are not helpful to patients for determining what they are likely to pay for a particular service or hospital stay." Ascension operates 153 hospitals and other facilities.

However, Ascension opposed the mandate to post prices on its website. Holtschneider wrote: "…expanding the current requirement without simultaneously providing meaningful and accessible information about coverage implications, uninsured discounts, and quality scores will be unhelpful—and may in fact be harmful—to supporting informed patient health care decisions."

Despite resistance from hospitals, they will have to post prices, and that information is likely to be a lot more helpful than what consumers can find on CMS's own hospital-cost calculator, Medicare Compare. You can bring up a specific hospital and it will list the same four procedures as other hospitals, give you the national average cost, and then tell you whether its cost is more or less than the national average. "Hospital Compare, the consumer-facing website produced by CMS, for instance, reports about 90% of hospitals as average on every measure," Leapfrog's Binder told the Senate committee. "This contradicts what we know from enormous bodies of research: that variation among providers is a hallmark of our health care system. They are not all the same."

But no good intentions go uncriticized in Washington, and that includes the CMS's efforts, however incremental, to increase transparency of hospital prices. Ivor Benjamin, MD,

president of the American Heart Association, wrote to the CMS saying, "AHA is concerned that bolstering price transparency without improving patient access to and understanding of quality data will not only fail to meet consumers' needs but could potentially be harmful."

Some Health Insurers and Employers Are Taking the Initiative on Posting Prices

The American Hospital Association also expressed trepidation about the CMS initiative and said that health insurers, not hospitals, should be posting data on prices. All of the major health insurers have "cost estimators" on their websites. A study published in 2016 in *The American Journal of Managed Care* queried 106 health plans servicing commercial clients and got useable responses from 31 health insurers based on their 2014 offerings. Ninety-four percent of plans allowed for provider comparison shopping and about 58% displayed estimates for prescription drug costs. The most commonly used procedures for which cost estimates were provided were: elective outpatient surgery (97%), radiology services such as x-rays and computed tomography scans (97%), and inpatient surgical services (97%). The accuracy of those estimators has not been established one way or the other.

Jaime King, Bion M. Gregory Chair in Business Law at the University of California, Hastings College of the Law, told the House Energy & Commerce Committee last July that a 2016 study showed only 3.5% of Aetna enrollees used an available online, personalized, episode-level price comparison tool, but costs for enrollees who used the tool to search for diagnostic services were 12% less than for those who did not use the tool.

Employers with self-funded health insurance plans have the freedom to work outside the constraints of a traditional insurance company. Steve Wojcik, vice president for public policy at the National Business Group on Health (NBGH), says NBGH's 2019 survey shows that 63 percent of respondents (all self-funded) plan to offer employees online decision-support tools, but that is down from 73 percent in a 2016 survey. However, the survey does not drill down into what those services consist of. It appears from the data that companies are moving more toward personal navigator services, in some cases to help an employee get accurate pre-medical service-price information, and in other cases to get a second opinion on whether a particular medical procedure is even necessary or to help determine the accuracy of a medical bill. The survey found that "high touch concierge services" increased from 29 percent in 2016 to an expected 39 percent in 2019.

DirectPath, a leader in benefits enrollment, health care transparency, and consumer third party administration (TPA), provides "high touch" services to some of its corporate clients who have self-funded health plans. Those companies do see a benefit to their employees and themselves of incentivizing workers to use accurate cost estimators, states Bridget Lipezker, senior vice president of advocacy and transparency at DirectPath. Some of her clients pay employees a percentage of the savings or a fixed dollar amount when a person contacts DirectPath, which provides estimates for low-, medium-, and high-cost providers, either physicians or physician/hospital combinations where inpatient or outpatient surgery is involved. DirectPath contacts physicians and hospitals directly to get price quotes, then submits a report to the employee, putting those quotes in the context of the employee's individual benefit plan, i.e., out-of-pocket and deductible obligations. DirectPath tries to exclude low-quality providers—for example, a physician rated "D" by the American Medical Association. If employees choose the lowest-cost provider(s) for a service, they get a financial reward from the employer, who also receives a financial benefit.

While DirectPath provides a more accurate cost estimate than many price transparency programs, it is not foolproof. The cost of an anesthesiologist's services are not projected when surgery is at issue, for example. And while DirectPath staffers talk to specific physicians and hospitals in an employee's geographical area, and provide details, for example, about which CPT codes will be billed, Lipezker acknowledges that there is no way to hold either the physician or the hospital to the initial estimate.

DirectPath also helps members find lower-cost prescriptions, although that service is not so targeted as what the company does for medical procedures. Drug-price cost estimators appear to be among the most frequent, new offerings from health plans. For example, this spring, Blue Shield of California and Gemini Health, LLC collaborated to introduce a new Drug-Cost Transparency Service™ enabling physicians to view patient-specific, lower-cost alternative medicines and compare prices while meeting with patients in their office. Providers, at no cost to themselves, can use their existing electronic health record (EHR) systems to check for alternative therapies and pharmacies, and out-of-pocket payments for patients, based on their plan, in each instance.

State Efforts

Some states also have come up with cost calculators, many of which are based on what are called all payer claims databases (APCDs). For example, New Hampshire Health Costs features a website that allows users to find a prospective procedure and the in-network charge based on their particular insurance plan. But there's a major shortcoming: For each procedure from each in-network hospital, the site indicates how "precise" that estimate is, and many are not very accurate. Moreover, consumers perusing the site won't learn what their out-of-pocket costs are, nor where they are regarding their annual deductible.

Maine established the first statewide APCD in 2003, and 20 states now have or are implementing APCDs with mandatory submission, while seven more states have APCDs with voluntary submission. Jaime King stated that the reliability and utility of state APCDs are compromised by their inability to obtain a comprehensive set of claims data because the Employee Retirement Income Security Act (ERISA) preempts any state law requiring self-insured employers to submit health care claims data. Congress could reverse this pre-emption loophole established by the Supreme Court in Gobeille v. Liberty Mutual Insurance, but no legislation to do so has been introduced.

But implementing state databases is no easy chore. Representative Kathy Castor (D-FL) says, "Florida is currently struggling with trying to launch another health care transparency website but now the cost is really escalating. It has been $4 million to get that up and running, and we don't have a lot to show for it."

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States are pursuing other initiatives in addition to websites and databases. This was true of California last year when Governor Jerry Brown signed a bill requiring manufacturers to notify insurers and state officials anytime they plan to raise the price of a medication by 16 percent or more over two years. Companies also have to provide justification for the increase. PhRMA filed a lawsuit to stop the bill from going into effect.

Clearly, efforts to improve health transparency, whether mandated by governments or instituted by employers, are advancing, albeit slowly. The impact of these early measures on actual drug, physician, hospital, and medical test prices appears to be minimal. In some cases, that is because opposition to the measure has led to its dilution. Consumer uptake is also lagging. The good news is there is plenty of room for improvement.

REFERENCE

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